TRUE NORTH COUNSELING, LLC
Find your inner compass

Office Financial Policy and Billing Agreement

Name (print): _____ Date of Birth: _____

Insurance Coverage:

* Client agrees to contact Insurance Company to verify Mental Health benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy. _____ (Initial)

* If insurance is being filed, any deductible not yet met is due at the time of service as well as any co-pay. _____(Initial)

* Should a dispute arise on a claim, it is generally the clients' responsibility to clarify and resolve the dispute with the insurance company. ____ (Initial)

Payment:

* If Insurance is not being filed, payment is expected at the time of service. ____(Initial)

* I agree to provide a 24-hour notice to cancel an appointment, otherwise no-show charges will be assessed. ____(Initial).

* If a client does not show for a scheduled appointment, there is a no-show/late cancel charge. 1st No-Show/late cancel = $50, 2nd No-Show/late cancel = $75, 3rd No-Show/late cancel = $100. ____ (Initial)

* A service requested by the client, but not covered by the client's Insurance Plan may be arranged under a separate written agreement with the provider. ____(Initial)

* Phone calls are not billable to your insurance. Phone calls over 10 minutes are billed for the time spent on the phone, at the pro-rated hourly rate of $2.50/minute. ____(Initial)

* Our fees are subject to change at the discretion of the practice. A fee schedule is available upon request. _____(Initial)

* There is a $20 administration charge for checks that do not clear the bank. _____(Initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the client or is duly authorized by or on behalf of the client to execute the above and accept its terms.

_____ _____

Signature of Client or Responsible Party Date

True North Counseling, LLC
5814 South 142nd Street
Omaha, NE 68137